MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
BUREAU OF HEALTH SYSTEMS
DIVISION OF LICENSING & CERTIFICATION

HOSPICE LICENSURE APPLICATION

Instructions

1. There are no licensure fees.

2. All parts of the application must be completed. Please answer all questions as of the current date. If any item does not apply, write N/A. There are three sections:

    a. The application for a Hospice License

    b. Attachment A

    c. Attachment B

3. Retain any necessary copies and return the original application and attachments to:

    MI Dept. of Community Health
    Bureau of Health Systems
    Division of Licensing & Certification
    Hospitals & Specialized Health Services Section
    P.O. Box 30664
    Lansing, MI 48909

4. There is no Certificate of Need for Hospice.

If you have any further questions please call (517) 241-3830

BHS-LC-107b (8/05)
Authority: P.A. 368 of 1978 as amended

Instructions: All parts of the application must be completed. Please answer all questions as of the current date. If any item does not apply, write N/A. and return the original application and attachments to:

MI Dept. of Community Health, Bureau of Health Systems
Division of Licensing & Certification, Hospitals & Specialized Health Services Section
P.O. Box 30664, Lansing, MI 48909

APPLICATION FOR A HOSPICE LICENSE

1. Hospice Name:_____ Phone: (___)_____—_____

3. Address: _____
   Street City Zip County

4. Federal Employer Identification Number: 3 8 - ___ ___ ___ ___ ___ ___ ___ (This is the number used to report employee income tax withholding)

5. Certificate of Need Application Pending: No _____ Yes _____ (Specify Number: _____)

6. Administrator's Name: _____
   (First) (Middle) (Last)

7. Is the program in leased real estate? No_____ Yes _____

   If yes, state name of lessor: _____

   Does the applicant have a direct or indirect interest in the lease other than as lessee: No _____ Yes _____

   If yes, state interest: _____

8. Certification by Applicant:

In accordance with the provisions of Act 368 of the Public Acts of 1978 as amended and the Hospice Administrative Rules of the Michigan Department of Community Health, the undersigned hereby applies for a license to operate a hospice program. I understand that any false statement or misrepresentation contained in this application form or its attachments will be the basis for denial or, if granted a license, subsequent revocation of such license.

I hereby certify that all phases of this hospice operation, including its training programs, comply with state and federal laws prohibiting discrimination and that the selection and appointment of physicians to the medical staff is without discrimination; solely on the basis of their licensure, registration, or their professional education as doctors of medicine or doctors of osteopathic medicine or surgery.

9. Applicant's Name: _____
(First) (Middle) (Last)

Telephone Number: ( ) —

Home Address: _____
Street City State Zip

Applicant's Signature: _____
Owner/Administrator Date

10. Attachments A & B must be completed and returned along with your completed application.

The issuance and processing of this application is governed by Administrative Rules 325.20201 through 325.20215. Failure to submit an accurate and complete application in a timely manner may result in denial of licensure. An applicant who makes a false statement in this application is subject to criminal penalties under Section 20142(5) of the Public Health Code (P.A. 368 of 1978, as amended).

ATTACHMENT A

Hospice Name:_____

I. Type of Hospice Ownership:

Individual		Non-Profit (Church)		County		Hospital Authority	
Partnership		Non-Profit (Other)		City			
Corporation		State		City/County			

II. Corporation Officers/Directors/Trustees (attach additional sheet if necessary):

Name	Address	Official Position	Principal Occupation

III. All persons having ownership interest, including stockholders with 5% or greater ownership (attach additional sheet if necessary):

Name	Address	Official Position	Principal Occupation

Authority: P.A. 368 of 1978 as amen

ATTACHMENT A (continued)

IV. Are any persons who have an ownership interest required to file a beneficial ownership report pursuant to the Federal Securities Exchange Act of 1934 (15 U.S.C. 78p, Sec 16(a))?

No_____ Yes_____ If yes, attach copies of such reports.

The term "affiliated" will refer to Michigan Department of Community Health Licensed/Certified Health Care Programs (Hospital, Nursing Care, Homes for the Aged, Home Health Agencies, Outpatient Physical Therapy Programs, Freestanding Surgical Outpatient Facilities, etc.) which share common ownership, administration, location for facilities.

V. If this hospice is affiliated with a licensed or certified health care program, please specify:

Name: _____

Address: _____

City:

Phone #: ( ) —

✳✳✳✳✳✳✳✳✳✳✳✳✳✳✳✳✳✳✳✳✳✳✳✳✳✳✳✳✳✳

Name: _____

Address: _____

City: _____

Phone #: ( ) —

Use additional pages if necessary, to list names and addresses.

ATTACHMENT B

Hospice Name: _____

I. Service Categories		Means of Providing Services		Name of Outside Contractee
		Directly **	Under Contract	
a.	*Medical Care			
b.	*Nursing Care			
c.	*Social Work			
d.	*Spiritual Care			
e.	*Bereavement Services			
f.	Nutrition Services			
g.	Short-Term Inpatient (Respite)			
f.	Shore-Term Inpatient (Acute)			
i.	Home Health Aide			
j.	Homemaker			
k.	Physical Therapy			
l.	Occupational Therapy			
m.	Speech/Language Pathology			
n.	Medical Supplies			
o.	Pharmaceutical Services			
p.	Medical Equipment			
q.	Follow-Up Services			
r.	Physician Assistant Services			
s.	Volunteer Services			
t.	Other (specify)			

***** Services required to qualify as a Hospice.
**Services provided are those offered directly by hospice paid or volunteer staff.

Authority: P.A. 368 of 1978 as amended

ATTACHMENT B (continued)

II. Number of active (current) hospice patients in each of the previous twelve months:

MONTH	# OF PATIENTS
January	
February	
March	
April	
May	
June	

MONTH	# OF PATIENTS
July	
August	
September	
October	
November	
December	

This hospice:

	YES	NO
(A) Charges or receives fees for goods or services provided.	_____	_____
(B) Receives third party reimbursement for goods or services provided	_____	_____